CHAPTER 12

Miscellaneous

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Preventive/Rehabilitative Services for Primary Care Enhancement (P/RSPCE)

Preventative/Rehabilitative Services for Primary Care Enhancement (P/RSPCE) is a service that is funded by the Medicaid State Plan. It was designed to address medically compromising risk factors, which interfere with a patient's ability to maintain an optimal state of health. P/RSPCE support primary medical care. The services are directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability.

It's goals are:

- To link patients with a primary care (medical) home
- To support appropriate use of the health care system
- To reinforce compliance with primary medical care
- To enhance the patient's optimal state of health
- To assist the patient to attain the highest possible level of independent functioning relative to his/her health

This service is available to waiver individuals when medically necessary and when it is:

- Needed to improve his/her response to treatment
- Needed for medication management, compliance with medication regime or assistance with procuring medications
- Needed to assure understanding of how multiple medical treatments relate with effectiveness of the plan to maximize the level of independent functioning.

The attached "Principles for Interaction" must be followed for waiver individuals receiving P/RSPCE.

Effective July 1, 2005, the South Carolina Department of Health and Human Services (DHHS) implement revised policies for the provision of P/RSPCE. Revisions to the policies are as follows:

- **Standing Order**

  The Standing Order (presently in place for public providers) will be limited to six (6) months. A provider must assist the Medicaid beneficiary with locating a Primary Care Physician (PCP) within six (6) months. If a PCP has not been established at the end of that six months, the services will no longer be billable.

- **Communication with Primary Care Physician (PCP)**

  It is essential that the medical home (PCP) approve of the P/RSPCE plan of care. The PCP must approve the plan of care for each individual either verbally or in writing within 30 calendar days. All records must contain documentation for approval of the plan of care from the PCP for service provision to be Medicaid billable. P/RSPCE

providers must maintain and document communication with the PCP throughout all phases of the patient's care.

- **Service Limitation**

  Providers are authorized to bill for a maximum of eight (8) 15 minute units for the Assessment and Plan of Care development and then a maximum of sixty-four (64) units per contract year for service delivery (i.e., Patient Education and Health and Behavior Intervention) per beneficiary. In the event of extreme and unusual circumstances, additional units can be requested by a PCP and may be authorized by the DHHS Review Committee. Only direct, one-on-one contact with the beneficiary, parent, and/or caregiver (e.g., infants or mentally impaired) will be billable. Use of P/RSPCE for the monitoring of a patient's healthcare appointments should be kept to a minimum; only beneficiaries with acute health issues should be monitored. Patients who have demonstrated overall compliance with healthcare instruction should require a minimum of contact or be discharged from services. All beneficiaries should be encouraged and urged toward self-management.

- **Medical Necessity Criteria**

  "Medical Necessity" means that the service is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability. Therefore, only issues that address the medical need(s) of the beneficiary whose Medicaid number is being billed will be reimbursable. Developmental, environmental, and psychosocial risks are billable only when these risks **directly** relate to the medical need as identified by the attending physician.

  Making and coordinating referrals to community resources such as a clothing bank, the housing authority, legal aid, and/or utility companies are not considered medical in nature.

- **Service Documentation**

  P/RSPCE providers are allowed to use check box forms for documentation; however, there must also be a service note summarizing the following:

  - specific risks from the plan of care that were addressed during the session;
  - the response of the beneficiary pertaining to each specific risk; and
  - additional risk(s) that were not resolved and the expected additional services that
  - are medically necessary.

Principles for Interaction
Between
Preventive/Rehabilitative Services for Primary Care Enhancement (P/RSPCE)
and
Medicaid Home and Community-Based Waiver Programs

- The short-term, time-limited, medical nature of P/RSPCE and its linkage to primary care are important in understanding the relationship between these two Medicaid services.

- The P/RSPCE provider must fully understand how the waiver program operates, the waiver and state plan services available, and scope of the Community Long Term Care case manager (CM)/Department of Disabilities and Special Needs service coordinator (SC). This is critical to avoid any unnecessary duplication or overlap services.

- It is important that the P/RSPCE provider and the assigned waiver individual's CM/SC communicate exactly what service(s) will be provided as well as the exact expected outcome of the intervention(s) being provided. This communication is necessary to ensure the individual's waiver plan of care/service is documented appropriately by the CM/SC.

- The P/RSPCE provider will document all telephone or personal contacts with the CM/SC in the client's case record.

- P/RSPCE services provided to waiver individuals must be within the 30 units/month limit established by DHHS. These services must be efficient, well managed, and must not duplicate any waiver or state plan services.

- DHHS will monitor the amount of P/RSPCE provided to waiver individuals through Medicaid expenditure reports.

- Only nutrition services can be routinely provided to waiver individuals under P/RSPCE.

- Any other P/RSPCE provided to home and community-based waiver individuals must meet one of the criteria below:

    1. Interventions related to a client's complicated medical condition to improve his/her response to treatment or care. There must be clear documentation that the P/RSPCE provider has communicated with the primary care physician and CM/SC concerning the nature of the service(s) to be provided;

    2. Interventions for clients with complicated medical conditions in need of medication management, compliance with a medication regimen, or assistance in procuring medications. Routine situations should be handled through Medicaid state plan (including Medicaid home health services) or waiver services. P/RSPCE involvement

should only be for crisis-type situations that are short-term, time-limited, medical, and carefully coordinated with the CM/SC; or

3. Interventions for clients with complex medical conditions to assure understanding of how multiple medical treatments relate with the effectiveness of the care plan in order to maximize the level of independence and functioning. This may involve attending a discharge or case coordination meeting (with the CM/SC) where a deinstitutionalization is imminent. This cannot duplicate the functions of the CM/SC.

- Waiver individual's meeting any of the above criteria may be referred for P/RSPCE by their CM/SC.

- These procedures will be communicated to the responsible P/RSPCE staff, CLTC staff, and DDSN staff.

Attachment: Contracted Provider List

Effective Date: September 1, 1998

For Your Information

Subject: *Out of State Travel*

Community Supports Waiver individuals may travel out of state and retain a waiver slot under the following conditions:

- *the trip is planned and will not exceed 90 consecutive days;*
- *the individual continues to receive a waiver service consistent with SCDDSN policy;*
- *the waiver service received is provided by a South Carolina Medicaid provider;*
- *South Carolina Medicaid eligibility is maintained.*

During travel, waiver services will be limited to the frequency of service currently approved in the individual's plan. Services must be monitored according to SCDDSN policy.

The parameters of this policy are established by SCDHHS for all HCB Waiver individuals.

PURGING A COMMUNITY SUPPORTS WAIVER FILE

- Clearly denote on the working file that there is a back-up file by placing a **Back-Up File Available** sticker on the front of the file or follow your agency's policy for denoting a Back-Up File Available.

- All material (except Waiver information) should be purged by calendar year and put in a file that is set up like the working file and labeled as a back-up file.

- The original Social History and all Social Updates remain in the file.

- All Service Agreements will be maintained in the working file.

- Client Rights and Review of Record Form remains in the working file.

- Voter Registration Information remains in the working file.

- Retain previous and current Plan in the working file.

- Current medical exam and medical records should be in the file.

- All psychological evaluations remain in the working file.

- Current and previous IEP/IPP, if applicable, should be retained in the working file.

- The E&P letter regarding eligibility should remain in the working file.

- Contact notes will be purged according to calendar year. The current year should remain along with two previous years to coincide with the budgets.

- For Waiver files, the Freedom of Choice, Waiver Enrollment letter, VR Letter/Request for Determination of Availability of Service Community Supports Form VR, Notice of Intent Community Supports Form 5, and all Level of Care determinations remain in the working file.

- Waiver budget information should be purged according to fiscal year (i.e.7/1/00-6/30/01) along with pertinent documents: referrals, monthly utilization forms, requisitions/invoices, and progress notes regarding Waiver provided services. The current contract period should remain along with the previous contract period. This should coincide with your contact notes (i.e. if the current contract period is 7/1/00-6/30/01 the you must retain this information in the working file along with 7/1/99-6/30/00 budget information and supporting documents which coincide with service notes from 1999-2001--the service notes would be purged back to 1/1/99).

South Carolina Department of Health and Human Services
Service Contacts
P.O. Box 8206
Columbia, SC 29202-8206

If you have concerns or questions regarding any waiver service, you must contact your District Waiver Coordinator. If when working with a provider of Community Supports Waiver services there are problems with direct billing to SCDHHS, etc. then refer them to their designated SCDHHS phone numbers listed below. You should NEVER make contact directly unless you have specific instructions from SCDDSN Central Office.

Community Long Term Care	898-2590
Specialized Medical Equipment, Supplies, and Assistive Technology	898-2882

TRANSFERRING A WAIVER FILE TO ANOTHER COUNTY

If a Community Supports Waiver individual moves to another county, he/she may be assigned a new Service Coordinator/Early Interventionist from the local DSN board or private provider in their new county of residence. Prior to the move, the current Service Coordinator/Early Interventionist will need to offer the individual/legal guardian a choice of Service Coordination/Early Intervention providers in

their new proposed county of residence. A list of providers can be found on the SCDDSN website (www.state.sc.us/ddsn). Once the choice is made, the following steps should be taken.

The Current Service Coordinator/Early Interventionist will:

1. Contact the new DSN board/provider to determine an agreeable date of transfer based on the individual's move date.

2. Communicate with the new DSN Board/provider the services that the individual is currently receiving and will need to continue to receive in their new county of residence. The new DSN Board/provider should begin working with the individual/legal guardian to choose providers of service in their new proposed county of residence. This should prevent a lapse of service unless a provider cannot be located.

3. Communicate with current providers to inform them of the move and date for termination of services.

4. Reconcile the services on the budget.

5. Inactivate the budget using BDINA. The date should be the last day the individual received services (Once the budget is inactivated, access to change anything must be done by SCDDSN Central Office Cost Analysis).

6. Ensure that the file is in order and all required information is included.

7. Submit the **Notice of Termination of Service Form (Community Supports Form 16-B)** to all service providers.

Once all of these steps are complete, the individual's file should be given to the Service Coordination/Early Intervention Supervisor for review, approval and final transfer to the new DSN Board/provider.

The current Service Coordination/Early Intervention Supervisor must:

1. Review the file to ensure that the budget has been appropriately adjusted and inactivated.

2. Review the file to ensure that the file is in good order and that all required information is included.

3. Contact the new DSN Board/provider to ensure that they are prepared to receive the case and that the effective date of transfer is appropriate.

4. Completed the **Memorandum of Confirmation of Transfer (Community Supports Form 21)** and forward, along with the original file, to the new DSN Board/Provider (Service Coordination Standards require the original file must be sent to the individual's new county of residence within ten (10) working days of notification of the move. The file must be current and the sending board/provider will maintain a complete copy of the file).

Please note: If the individual is in an Alternative Residential Placement, the Office of Behavioral Supports at SCDDSN will need to be notified of the move along with the appropriate District Office.

You must:

1. Contact the individual/legal guardian to initiate Community Supports Waiver services.

2. Contact SCDDSN Central Office Cost Analysis Division [Donna M. Johnson (803) 898-9782 or Trina Smalley (803) 898-9630] to set up a new Community Supports Waiver budget. This must be completed before the individual can begin receiving Community Supports Waiver services in the new county.

3. Complete a new Community Supports Waiver budget within two (2) working days. There should be no lapse in services. If a individual is receiving a service daily you will need to obtain verbal approval from the appropriate Community Supports Waiver Coordinator.

Please note: If the individual is moving out of state the budget will need to be reconciled and inactivated and **Notice of Disenrollment (Community Supports Form 17)** will need to be completed. You will follow the normal procedures for disenrollment.